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ABSTRACT

Although college students are generally knowledgeable about Acquired Immune Deficiency Syndrome (AIDS) and how it is transmitted, many heterosexual college students fail to engage in AIDS-preventive behavior. This study examined heterosexual college students' perceptions of their own and other peoples' vulnerability to AIDS and explored the relationship between perceived vulnerability and AIDS-preventive behavior. Instruments assessing perceived vulnerability, high-risk and AIDS-preventive behavior, and AIDS knowledge were completed by 80 sexually active heterosexual college students, none of whom reported use of intravenous drugs. The results revealed that the students estimated their own risk of contracting AIDS to be significantly lower than the risk for all others. Analyses of variance indicated that males, homosexual males and females, and young adults not in college were perceived as more likely to contract AIDS. AIDS knowledge was related to accuracy of risk estimates, but was not predictive of AIDS-preventive behavior. Lack of AIDS-preventive behavior appears related to illusions of invulnerability and the characterization of AIDS as an outgroup problem. The findings suggest implications for AIDS-prevention education programs. (Author/NB)

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**Perceptions of Vulnerability:
Impact on AIDS-Preventive Behavior
Among College Adolescents**

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Abstract

Perceptions of own and others' risk of contracting AIDS, AIDS knowledge and extent of AIDS-preventive behavior (APB) were assessed in sexually active heterosexual college students (N=80) to investigate why many college students fail to enact APB. Own risk was estimated as significantly lower than risk for all others, $p < .0001$. ANOVAs indicated that males ($F=60.13$, $p < .0001$), homosexual males and females ($F=62.55$, $p < .0001$), and young adults not in college ($F=8.17$, $p < .005$) are perceived as more likely to contract AIDS. AIDS knowledge was related to accuracy of risk estimates, but was not predictive of APB. Lack of APB is discussed in terms of illusions of invulnerability and the characterization of AIDS as an outgroup problem. Implications for AIDS-prevention education programs are discussed.

Perceptions of Vulnerability:
Implications for AIDS-Preventive Behavior
Among College Adolescents

In the absence of a vaccine or cure for Acquired Immune Deficiency Syndrome (AIDS), control of the infection must be accomplished through prevention. AIDS-preventive measures involve the avoidance of behaviors in which there is a chance that Human Immunodeficiency Virus (HIV)-infected bodily fluids might enter the bloodstream of an uninfected person; the sharing of needles in intravenous drug use and engaging in unprotected sexual intercourse are two common modes of disease transmission.

Although college students are generally knowledgeable about AIDS, including the ways it is transmitted, most of them report that they take no special precautions against HIV infection (DiClemente, Forrest, & Mickler, 1990; Mangan, 1988). Results of a national survey of college students revealed that nearly 50% of the heterosexual respondents reported multiple sexual partners, and that approximately 60% used condoms less than half the time they engaged in sexual intercourse (DiClemente et al., 1990).

Why are heterosexual college students failing to engage in AIDS-preventive behavior? A key component of two widely utilized psychological models of peoples' responses to health threats suggests an answer: Both the Health Belief Model (Rosenstock, 1974) and Protection-Motivation Theory (Rogers, 1983) posit that preventive behavior is motivated, in large part, by perceptions of vulnerability. If people do not perceive themselves as susceptible to a particular health threat, they are not likely to

adopt self-protective behaviors. Thus persons who do not believe they are at risk for AIDS will not be likely to engage in AIDS-preventive behavior. It is proposed that heterosexuals in general, and particularly adolescent heterosexuals, are not protecting themselves because they do not feel vulnerable to AIDS.

But are perceptions of vulnerability always accurate? An extensive psychological literature, both theoretical and applied, suggests that perceptions of vulnerability to threat are often distorted as a coping response to minimize the threat (e.g., Bell & Byrne, 1978; Burger & Burns, 1988; DiClemente, Zorn, & Temoshok, 1987; Leventhal, 1970; Perloff, 1987; Rogers & Mewborn, 1976). When faced with a personally relevant threat, especially a threat to one's health, an individual is likely to cognitively restructure (i.e., distort) the threat in an attempt to reduce or control it.

Perceptions of vulnerability to AIDS may be distorted among members of the general population, such that heterosexuals who do not use drugs intravenously believe that they are not at risk for HIV; they also tend to underestimate the prevalence of AIDS in the majority population (DiClemente, Forrest, & Mickler, 1990; Laumann, Gagnon, Michaels, Michael, & Coleman, 1989). This tendency to underrate susceptibility may be especially true among adolescents, who characteristically view themselves as invincible (Burger & Burns, 1988; Perloff, 1987).

One phenomenon which may promote perceptions of invulnerability to AIDS among heterosexuals is the distinction

between high- and low-AIDS-risk groups by epidemiologists and other members of the medical community. This may have fostered misperceptions concerning susceptibility within the general population since HIV incidence, in its early years, has been located primarily within homosexual male and intravenous drug-user populations in the United States. The conspicuous dissimilarities between these groups and the general population underscores the distinction between them and likely promotes the belief that AIDS is a disease of other, different persons with whom the majority does not identify (i.e., outgroups).

The view of AIDS as an outgroup problem may diminish as heterosexual AIDS becomes widespread, but by then it will be too late for prevention. Recent figures from the Centers for Disease Control show an approximate 400% increase in heterosexual HIV infection among adolescents and adults over the past three years; this reflects a 300% increase in the 13- to 30-year-old population across the same time period (Centers for Disease Control, 1986; 1990). Reports that equal numbers of boys and girls are becoming infected suggest that HIV is being transmitted through heterosexual intercourse (AIDS is Spreading to Teen-agers, 1989).

A second potential barrier to accurate perceptions of vulnerability to AIDS is the illusion of unique invulnerability, a self-serving bias that affects peoples' assessments of the probability of negative events occurring to them. In general, although people may be fairly accurate in appraising the chances that others will experience misfortune, they tend to under-

estimate their own chances of negative outcomes, ranging from divorce to natural disaster to disease susceptibility. Illusion of invulnerability has been demonstrated even when persons are confronted with objective fact (e.g., statistical probabilities) about their own chances of encountering a negative outcome; they seem to believe that they personally are immune to such negative events (Kunda, 1987). Adolescents seem to be particularly susceptible to such illusions of invulnerability and often fail to take appropriate measures to prevent foreseeable dangers, such as pregnancy and exposure to HIV infection (Burger & Burns, 1988; Lehman & Taylor, 1987; Perloff, 1987).

The present study assessed heterosexual college adolescents' perceptions of their own and other peoples' vulnerability to AIDS and explored the relationship between perceived vulnerability and AIDS-preventive behavior. It was hypothesized that college-aged heterosexuals would judge themselves to be less vulnerable to AIDS than other persons. It was expected that the patterns of discrepancy in perceptions of own and others' vulnerability might suggest an explanation for the reasons college students believe they are less at risk for AIDS: If there is a belief that AIDS is an outgroup problem, they should view themselves as relatively less vulnerable to AIDS than members of so-called high-risk groups. However, if adolescents are particularly susceptible to illusions of invulnerability, not only should they perceive themselves as less at risk than IV drug users and homosexual males, but they should also see themselves as less vulnerable than persons who are essentially similar, such as other

heterosexual college students or heterosexuals in general. It was also proposed that perceived invulnerability would be related to failure to engage in AIDS-preventive behavior. Further, it was expected that knowledge about AIDS would lead to more accurate estimates of risk to self and others (i.e., smaller discrepancies between judgements of own and others' risk), and that it might be predictive of AIDS-preventive behavior.

Method

Participants

Ninety-five self-reported heterosexual undergraduate college students recruited from introductory psychology classes comprised the original sample. Because 5 male and 10 female participants (approximately 15% of participants of both genders) reported that they had never engaged in sexual intercourse, their data was not included in the analyses to be reported: Since AIDS can be sexually transmitted, assessment of risk is necessarily affected by whether or not one is sexually active. Likewise, because intravenous drug use is a known transmission risk, respondents were screened on this factor; none of the participants reported using drugs intravenously. Regarding potentially relevant demographic characteristics, the subsample of 80 sexually active participants was 69% female and 31% male; 90% White, 7% Black, and 3% Hispanic; 77% Catholic, 20% Protestant, while 3% claimed no religious affiliation.

Instruments

Vulnerability was assessed via three questionnaire items:
(1) participants' perceptions of personal risk of contracting

AIDS, rated on a 10-point scale where 1=no risk and 10=very high risk; (2) their degree of worry about contracting AIDS indicated on a 10-point scale by 1=no worry and 10=extreme worry; and (3) a percentage estimate of own chance of becoming infected with HIV within the next two years (estimate range=0%-100%).

Percentage estimates of eight hypothetical other persons' chances of contracting AIDS were also obtained using the same 0%-100% scale. These persons were described in only the broadest of terms but included prototypical members of high- and low-risk groups. Participants were asked to render judgements of risk for the following persons: The average heterosexual college woman and man; the average college-aged heterosexual woman and man who do not attend college; the average homosexual college woman and man; the average college-aged homosexual woman and man who do not attend college.

High-risk and AIDS-preventive behavior was assessed by asking respondents the extent to which they had increased or decreased the frequency of the following sexual behaviors due to concern about AIDS: Numbers of sex partners, use of condoms, oral sex and anal sex. In addition, they were asked to indicate the percentage of times (0%-100%) that they used condoms during intercourse. To appraise more general risk-taking, participants were also asked whether their use of alcohol or drugs had changed in response to AIDS.

AIDS knowledge was measured using a 21-item scale concerning modes of HIV transmission and common misconceptions about the risks of casual contact (DiClemente, Zorn, & Temoshok, 1987).

Procedure

In small group sessions participants were informed of the purpose of the study, without disclosure of the specific hypotheses, before informed consent was obtained. Respondents were assured confidentiality and full anonymity; no identifying information was collected. Participants then completed the instruments described in the preceding and were subsequently debriefed in groups.

Results

Mean Responses to Dependent Measures. The theoretical range of percent estimates of own and others' chances of contracting AIDS was 0-100%. Mean percentage estimates for self and others are included in Table 1. Means for perceived risk of AIDS to self and worry about the self contracting AIDS were 2.54 and 4.89, respectively; both were assessed on 10-point scales.

Behavior change variables were scaled as follows: a rating of 1 signified a great decrease in a specific behavior, 2 indicated a decrease in the behavior, 3 meant that the frequency of the behavior had not changed, a rating of 4 stood for an increase, while a 5 indicated a great increase in the behavior. A rating of 0 was used by respondents if they did not engage in a particular behavior. Mean ratings of change for the behaviors assessed are as follows: Alcohol use, $\bar{X}$ = 2.33; Drug use, $\bar{X}$ = 0.42; Number of sexual partners, $\bar{X}$ = 2.04; Condom use, $\bar{X}$ = 3.06; Anal sex, $\bar{X}$ = 0.46; Oral sex, $\bar{X}$ = 2.05. Note that very little change was reported overall: Most means are close to 0 or to 3, indicating no participation or no change in frequency of the

behavior, respectively. The greatest amount of change occurred due to decreases in number of partners and oral sexual activity, but even this change is modest. Frequency of condom use was reported on a separate scale using a range of values from 0-100% of the times that respondents engaged in intercourse. Mean frequency of condom use was 52.60% of the times participants engaged in sexual intercourse. Analyses of Variance were conducted to test for possible gender differences on the behavior change variables. Only one significant difference was shown: Females ($M=1.81$) reported a greater decrease in oral sexual activity than did males ($M=2.63$), $F(1,76)=5.93$, $p<.02$.

Perception of Invulnerability. To assess illusion of invulnerability, mean percentage estimates of own risk of AIDS and perception of risk for the eight hypothetical others were compared via t-tests. Risk to the self was estimated as significantly lower than risk for all eight of the other target persons (all $p < .0001$). Mean risk estimates for self and others and t-statistic values also are presented in Table 1.

Insert Table 1 about here

AIDS as an Outgroup Problem. To examine whether certain groups of people are perceived to be at higher risk for AIDS, a 2 (sex of subject) x 2 (college vs. non-college status of hypothetical other) x 2 (heterosexual vs. homosexual orientation of other) x 2 (male vs. female gender of other) Analysis of Variance (ANOVA) with the last three factors as repeated measures was conducted.

Since there was no significant effect of participant gender, results of the analysis are reported collapsed across gender of participant. Results indicated that males ($M = 43.26$, $F[1, 77] = 60.13$, $p < .0001$), male and female homosexuals ($M = 45.34$, $F[1, 77] = 62.55$, $p < .0001$), and young adults not in college ($M = 39.10$, $F[1, 77] = 8.17$, $p < .005$) were perceived as more likely to contract AIDS than females ($M = 31.62$), heterosexuals ($M = 29.54$), and persons attending college ($M = 35.78$), respectively.

AIDS Knowledge. To examine the influence of AIDS knowledge upon estimates of risk for self and others, the distribution of knowledge scores was split into approximate thirds to create levels of AIDS knowledge. According to a data-based split, 31% of participants scored 15 or less on the knowledge scale and so were classified as low in AIDS knowledge; 28% scored 16 or 17 correct and were categorized as moderate in AIDS knowledge; 41% scored above 17 and were ranked as high-knowledge participants (maximum score was 21 points). ANOVAs were conducted using level of knowledge as the independent variable and risk estimates for self and others as dependent variables. Results showed that risk estimates made by high-knowledge participants were significantly lower for all eight hypothetical target others than the estimates of low-knowledge participants. Differences in the magnitude of risk estimates for high- and moderate-knowledge participants were significant only for some of the target others, as is shown in Table 2. There was no effect of AIDS knowledge upon estimates of own risk ($F[2, 77] = 1.12$, $ns.$): Although there was a smaller discrepancy in high-knowledge participants'

estimates of risk to self and others they also, like those with low or moderate knowledge, assessed their own risk as significantly lower than risk to others. Because the empirical split did not divide participants into exact thirds, additional ANOVAs were conducted using a theoretical tertiary split on AIDS knowledge: Results of these analyses did not differ significantly from those conducted with the empirically-based split. Finally, level of knowledge was not related to degree of worry about contracting AIDS, $F[2, 79] = 1.09, p < .10$, or perceived risk, $F[2, 77] = 1.94, p > .10$.

Insert Table 2 about here

In general, level of AIDS knowledge was not related to risky or AIDS-preventive behaviors. A marginally significant effect for condom use ($F[2, 77] = 3.03, p < .06$) indicated that persons with moderate AIDS knowledge tended to decrease their condom usage in response to AIDS ($M = 2.38$), while those with high ($M = 3.38$) and low knowledge ($M = 3.26$) reported no change in condom use. A trend also related to condom use revealed the same pattern of means: For percent of times condoms are used during intercourse (0-100%), moderate-knowledge respondents reported using condoms less ($M = 40.37$) than low- ($M = 49.44$) or high-knowledge ($M = 65.32$) participants ($F[2, 70] = 2.31, p < .11$).

Risk, Worry, Knowledge and Behavior Change. The relationship between perceptions of AIDS risk, worry about AIDS, knowledge and behavior was examined via correlational analyses. Perceived risk

was related positively to AIDS worry ($r[78] = .513, p < .0001$) and negatively to AIDS knowledge ($r[78] = -.264, p < .02$) such that greater worry and less knowledge were associated with higher perceived risk, respectively. Worry about AIDS was unrelated to AIDS knowledge ($r[78] = -.156, p < .16$) but correlated negatively with oral sexual activity ($r[78] = -.238, p < .04$): greater worry was associated with decreases in oral sex. Knowledge about AIDS was not related to any of the behavior change variables.

Due to the paucity of significant relationships between perceived risk, worry and behavior, additional correlational and factor analyses were conducted to construct composite variable indices to increase the strength of any correlations between these variables. Since AIDS risk and AIDS worry were found to be significantly correlated, they were combined to create a composite variable labeled AIDS vulnerability. Because perceived AIDS risk and percent estimate of own chance of contracting AIDS were less highly related, $r(78) = .327, p < .003$, and worry about AIDS and percent estimate of own risk were only weakly related, $r(78) = .203, p < .07$, these variables were not included in the vulnerability index.

Regarding the behavior variables, number of partners was shown to be correlated to oral sexual activity, $r(78) = .410, p < .0002$, and marginally with alcohol use, $r(78) = .204, p, .07$ and anal sex, $r(78) = .201, p < .07$. Changes in condom use were correlated to percent estimates of frequency of condom use, $r(71) = .451, p < .0001$. A principal components factor analysis on the behavior variables yielded two factors that jointly accounted for

74% of the variance. The two condom use items (changes in use: .589; frequency of use: .521) loaded most heavily on Factor 1, labeled condom-use index. Oral sex (.426), and number of partners (.401) comprised Factor 2, which were combined as an index of sexual risk taking.

AIDS vulnerability was significantly related to changes in oral sexual activity, $r(76) = -.256$, $p < .03$; the higher the perceptions of vulnerability, the greater the decrease in oral sex (recall that lower scores indicate a decrease). There was no significant association between vulnerability and the composite behavior indices, condom use ($r[69] = .015$, $p < .90$) and sexual risk taking ($r[76] = -.194$, $p < .09$).

AIDS vulnerability was also correlated to knowledge, $r(78) = -.247$, $p < .03$, such that lower perceived vulnerability was associated with higher knowledge. In addition, a positive relationship was found between AIDS vulnerability and percent estimates of risk to self ($r[78] = .296$, $p < .009$), indicating that persons with greater perceptions of vulnerability made higher estimates of their likelihood of contracting AIDS.

Participants were split according to their levels of perceived AIDS vulnerability and ANOVAs were conducted using two levels of vulnerability (determined by median split) as independent variables. Again, dependent measures were the behavior change variables and percent estimates of risk to self and others. A marginally significant effect of vulnerability was found for oral sex, $F(1,76) = 3.58$, $p < .06$. Although not significant in post-hoc Duncan's tests, the pattern of means

showed that those high in perceived vulnerability ($M = 1.77$) tended to decrease their oral sexual activity more than did participants who were low in perceived vulnerability ($M = 2.36$).

The effect of vulnerability upon percentage estimates of own and others' chances of contracting AIDS was more powerful and broader: Persons who believed themselves to be more vulnerable to AIDS made significantly higher estimates of own and others' chances of becoming infected with AIDS, except for the case of homosexual college women. In this one instance, the estimates of high and low vulnerability participants did not differ. The relevant means and F statistics are presented in Table 3.

Insert Table 3 about here

Discussion

The findings clearly demonstrate that respondents believe they are at low risk for contracting AIDS and are relatively less susceptible to HIV infection than other persons. The average respondent believed that his or her own chance of contracting AIDS was less than 8 in 100, while the grand mean estimate for other persons (collapsed across college status, gender, and sexual orientation variables) was approximately 38 in 100. The pattern of differences in perceived risk for self and others may help to explain why such perceptions of invulnerability exist.

It is apparent that a general illusion of invulnerability is operating since persons estimated their own risk as dramatically lower than risk for any of the hypothetical others -- even those

persons who were quite similar to them in terms of broad category membership. If AIDS were being perceived as solely a problem of outgroups, then estimates of personal risk should have been significantly lower only when compared to risk estimates for the most dissimilar others, especially homosexual males who have been publicized as persons at high risk.

However the data do provide some support for the notion that AIDS is perceived as an outgroup problem: Males, homosexuals and persons not in college were thought to be more likely to contract AIDS than females, heterosexuals or college students. Recall that the sample was predominantly female (70%), and entirely heterosexual (100%) and enrolled in college (100%); it is clear that dissimilar others are perceived as more likely to contract AIDS. Thus the results may thus reflect an ingroup positivity bias whereby respondents believe that "people like me don't get AIDS".

Alternatively, it may be that participants believe that males, homosexuals, and persons not in college engage in more high-risk sexual behavior. Generally speaking, the rate of adolescent sexual activity is higher among males than females; certainly male homosexuals who practice anal intercourse are at higher than average risk; also respondents may think it plausible that college-educated people are more informed about risks and preventive aspects of sexual behavior and so are more careful regarding sex, although the high rates of sexual activity and sexually-transmitted diseases on college campuses contradicts this belief. These data, unfortunately, do not specifically

address the origin of beliefs of higher susceptibility for persons in these three groups. However, the occurrence of high risk estimates for homosexual females supports the idea that an ingroup-outgroup distinction is operative rather than fact-based risk estimates, since objective information about modes of transmission and rates of infection indicate that homosexual women actually are at extremely low risk because they are not involved with male carriers of HIV.

AIDS-preventive behavior could not be predicted and was not correlated to risk, worry or knowledge in any consistent way. No doubt there was a statistical restriction of range problem due to the fact that so little AIDS-preventive behavior was reported. Means for these variables showed that some of the behaviors occurred only rarely (e.g., anal sex) so that there was no change to report; for other behaviors little, if any, change in frequency was reported. The largest range of values reported was for condom use and for oral sexual behavior. Although condom use was only marginally related to the major independent variables, oral sex was found to be significant in several instances. Perhaps if respondents had been asked about the frequency with which they engaged in each of the behaviors instead of the degree to which they had changed their behaviors in response to AIDS, a wider range of responses would have been obtained, yielding more variance and allowing for the identification of the factors associated with that variability.

Consistent with previous studies (DiClemente et al, 1990; MacDonald et al., 1990) knowledge about AIDS was not related to

AIDS-preventive behavior (APB). Even among participants who were highly knowledgeable about AIDS there was no greater tendency to engage in APB. Apparently knowing about the risks of AIDS is not sufficient to motivate self-protective behavior. In fact, in the present study, greater AIDS knowledge was associated with decreased perceptions of vulnerability to AIDS. The cliché that a little knowledge is dangerous may be relevant here: If educational programs contain only facts about AIDS, people who do not fit neatly into the "high risk categories" or engage in risky behaviors "very often" may feel reassured and confident that they are not vulnerable.

Lacking from current AIDS- education programs is a component that stresses the personal relevance of the problem and promotes a realistic assessment of risk (i.e., without psychological distortion). Without the perception of some degree of risk, protective behaviors are not likely to be enacted. The target audience must be convinced that they, too, are vulnerable to HIV infection; at the least they should be taught to acknowledge that there is some possibility --however remote-- that they could contract the disease. Often, when persons are informed of the 300-400% increase in the 13-30 year-old population in recent years they express shock; when informed that the heterosexual population is becoming increasingly infected, they are disturbed. This information should be included in educational programs in order to motivate their adoption of preventive behaviors. The aim of including such information is not to scare them, as the use of fear appeals has problems inherent (e.g., Janis &

Feshbach, 1953; Leventhal, 1970; Rogers, 1984), but rather to inform and convince heterosexual adolescents that there is a chance, however small, that they could contract AIDS themselves. If this can be accomplished, it is likely that protective behaviors would follow.

Present educational programs fail to include information that would motivate AIDS-preventive behavior. The fact that respondents reported little decrease in risky behaviors or increase in protective behavior is not surprising in light of current AIDS-prevention education programs, and Health Belief Model and Protection-Motivation Theory predictions concerning preventive behavior in persons who do not believe they are at risk.

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Table 1

Mean Percentage Estimates of Risk of AIDS
for Self and Eight Hypothetical Others

<u>Person</u>	<u>Mean %</u>	<u>t-value</u>
Self	7.96%	
Average Heterosexual College Woman	26.31%	8.29
Average Heterosexual College Man	30.65%	9.76
Average Heterosexual Woman of same age who is not in college	28.63%	8.52
Average Heterosexual Man of same age who is not in college	33.01%	9.71
Average Homosexual College Woman	33.51%	8.83
Average Homosexual College Man	53.38%	16.31
Average Homosexual Woman of same age who is not in college	38.15%	10.30
Average Homosexual Man of same age who is not in college	56.35%	17.31

Note. Percentage estimates of risk could range from 0%-100%.

Risk estimates for all hypothetical others are significantly higher than estimate of risk to the self, $p < .0001$.

Table 2

Mean Percentage Estimates of Others' AIDS
Risk By Level of AIDS Knowledge

	<u>Low</u>	<u>Moderate</u>	<u>High</u>	<u>F</u>
Heterosexual College Woman	31.63a	30.82a	18.48b	3.75*
Heterosexual College Man	38.78a	33.09ab	21.83b	4.60**
Heterosexual Non-College Woman	36.81a	29.18ab	21.10b	3.50*
Heterosexual Non-College Man	43.96a	33.96ab	22.80b	5.69**
Homosexual College Woman	49.56a	30.04b	21.60b	10.54***
Homosexual College Man	68.07a	57.46a	37.17b	12.61***
Homosexual Non-College Woman	55.37a	34.46b	25.37b	11.59***
Homosexual Non-College Man	70.18a	59.04a	41.93b	9.55***

Note. Means without common superscripts are significantly different from each other.

*** $p < .001$

** $p < .01$

* $p < .05$

Table 3

Mean Percentage Estimates of Own and Others'
AIDS Risk By Level of Perceived Vulnerability

	<u>Vulnerability</u>		<u>F</u>	<u>p</u>
	<u>Low</u>	<u>High</u>		
Self	4.85	11.23	6.79	.01
Heterosexual College Woman	20.36	32.56	7.23	.01
Heterosexual College Man	24.75	36.84	6.07	.01
Heterosexual Non-College Woman	21.71	36.46	9.53	.002
Heterosexual Non-College Man	24.76	41.69	10.02	.002
Homosexual College Woman	28.50	38.64	3.08	.08
Homosexual College Man	45.55	61.40	7.42	.01
Homosexual Non-College Woman	31.17	45.38	5.78	.02
Homosexual Non-College Man	48.25	64.67	7.84	.01